

## **MARS Application Instructions**

Thank you for inquiring about eligibility for Madison Assisted Ride System. Enclosed is a copy of our MARS application. Also enclosed is a brochure that explains what MARS is and who is eligible for these services. **Please read these instructions and the enclosed brochure carefully before completing the application form.**

### **MARS Eligibility Requirements**

According to the Americans with Disabilities Act (ADA), a disabled individual is one who has a "physical or mental impairment that substantially limits one or more of the major life activities of such individual". The MARS service was created with the sole purpose of providing transportation services to individuals living within Madison's City limits who are considered to be "disabled" under ADA guidelines. To be eligible to use the MARS service, an individual must have an impairment that clearly prevents or limits his or her ability to operate a motor vehicle.

### **How do I Apply?**

The enclosed forms must be filled out completely and returned to the address provided below. The first form is for you or your caregiver to complete in order to provide us with the information we need to evaluate your application. The second form should be completed by your physician or other licensed professional health care provider who is able to verify the information on your application and provide any additional information about how your disability prevents you from using traditional methods of transportation. Before taking the form to your physician, you should complete and sign the Authorization to Release Medical Information at the top of that form. Once all information on the form is completed, you may mail or fax both forms to:

City of Madison  
Department of Recreation  
100 Hughes Road  
Madison, AL 35758  
Fax: (256) 772-9377

**If you have questions, please call (256) 772-9300**

## CITY OF MADISON MARS APPLICATION

For office use only:

Date Received: \_\_\_\_/\_\_\_\_/\_\_\_\_

File # \_\_\_\_\_

We are requesting this information in order for MARS to serve you. This information will not be provided to any other person or agency except those you list on this application.

Incomplete forms will be sent back to you. This will slow down the certification process.

### GENERAL INFORMATION (PLEASE PRINT OR TYPE)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M/I \_\_\_\_\_

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Telephone: Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M\_\_\_\_ F\_\_\_\_

Address where MARS will pick you up, if different from above:

\_\_\_\_\_

Emergency Contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Did someone assist you in filling out this form? Yes: \_\_\_\_ No: \_\_\_\_

Should this person be contacted if additional information is needed? Yes: \_\_\_\_ No: \_\_\_\_

If 'No' was checked in the above question, please list an individual is allowed to provide additional information:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_

### INFORMATION ABOUT YOUR FUNCTIONAL ABILITIES

1. Do you currently travel with a personal care attendant or escort?

\_\_\_\_ Yes \_\_\_\_ No

2. If you travel with the assistance of an escort, what type of assistance do they provide?

\_\_\_\_ Mobility

\_\_\_\_ Medication

\_\_\_\_ Transfers

\_\_\_\_ Other: \_\_\_\_\_

3. Do you use any of the following mobility aids or specialized equipment?

\_\_\_\_ I do not use any mobility aids.

\_\_\_\_ Cane

\_\_\_\_ White Cane

\_\_\_\_ Motorized Wheelchair

\_\_\_\_ Walker

\_\_\_\_ Scooter

\_\_\_\_ Manual Wheelchair

\_\_\_\_ Leg Braces

\_\_\_\_ Crutches

\_\_\_\_ Respirator/ Portable Oxygen Tank

\_\_\_\_ Service Animal

\_\_\_\_ Other \_\_\_\_\_

**Please Note:** A wheelchair or other mobility device must meet the definition of a "common wheelchair" as specified in the ADA regulations: i.e., not more than 30" wide and 48" long when measured 2" from the floor and must weigh less than 600 lbs when occupied.

4. Using a mobility aid on your own, how far can you travel?

\_\_\_\_ I cannot travel outside my home or apartment

\_\_\_\_ I can get to the curb in front of my home or apartment

\_\_\_\_ I can travel up to 200 feet

\_\_\_\_ I can travel up to ¼ mile

\_\_\_\_ I can travel over ¼ mile

5. How do you currently travel? (Check all that apply)

\_\_\_\_ Drive myself

\_\_\_\_ Someone else drives me

Other: \_\_\_\_\_

\_\_\_\_ Regular Bus (Shuttle)    \_\_\_\_ Taxi

6. According to the Americans with Disabilities Act (ADA), a disabled individual is one who has a “physical or mental impairment that substantially limits one or more of the major life activities of such individual”. The MARS service was created with the sole purpose of providing transportation services to individuals living within Madison’s City limits who are considered to be “disabled” under ADA guidelines. To be eligible to use the MARS service, an individual must have an impairment that clearly prevents or limits his or her ability to operate a motor vehicle. Do you have an impairment that clearly prevents you from operating a motor vehicle?

\_\_\_ Yes \_\_\_ No

7. Can you maintain balance while seated on a moving vehicle?

\_\_\_ Yes \_\_\_ No

8. Can you independently get on and off of a lift-equipped bus or climb three (3) 10” steps?

\_\_\_ Yes \_\_\_ No

9. Can you find a seat by yourself without assistance of another person?

\_\_\_ Yes \_\_\_ No

10. List your 3-4 most frequent destinations and how you currently get there:

Destination Address	Frequency Of Travel	How do you currently get there?

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**For Applicants with Vision Disabilities**

1. Cause of vision loss/ diagnosis \_\_\_\_\_
  2. Are you totally blind? Yes \_\_\_\_\_ No \_\_\_\_\_
  3. My vision is worse during these conditions:  

_____ Bright Sunlight	_____ Dimly lit or shaded places
_____ Nighttime	_____ About the same in all lighting
  4. My eye condition is considered to be:  

_____ Stable	
_____ Degenerative	
_____ Other (please explain) _____	
  5. Most often, I use the following mobility aids when I walk outdoors:  

_____ Sighted (person) guide	_____ Optical devices (telescope, light, special glasses, etc.)
_____ Dog guide	_____ None of the above
_____ Long white cane	_____ Other (please list)
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### **CERTIFICATION OF APPLICATION**

I hereby certify that, to the best of my knowledge, information given in this application is correct. I understand that the application will be returned if it is not completed. I further understand that the results of this review will be based on ADA definitions and guidelines and may require additional information from me, such as additional consultation from my physician or other professional. I understand that failure to adhere to the policies and procedures for using MARS may be grounds for suspension or revoking my eligibility to participate in this program.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please review each of your answers to make sure that you have completed all of the questions to the best of your ability.**

**Thank you.**

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(TO BE COMPLETED BY APPLICANT)

I hereby authorize the following licensed professional who can verify my disability or health related condition to release information to the City of Madison Recreation Department. The information will be used only to verify my eligibility for transportation services. I understand that I have a right to receive a copy of this authorization, and that I may revoke it at any time.

Name of Professional who may release my medical information: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Applicants Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Instructions for Medical Verification Form To be completed by Doctor or Healthcare Professional

It is important to determine if the above applicant is applying for the Madison Assisted Ride Program because their disability or health conditions completely prevent conventional travel some or all of the time. The MARS program was NOT developed to be used as a 'convenient' travel option, but rather, a service to individuals who are truly in need.

The above named applicant has indicated that you can provide information regarding his or her disability and its impact upon his or her ability to utilize our transit services. The MARS program will provide services to eligible persons whose disability prevents them from utilizing other methods of transportation. The information you provide will allow us to make an appropriate evaluation of this request and its application to specific trip requests. Thank you for your cooperation in this matter.

**The term "disabled" for our purposes is defined as: Any person who by reason of illness, injury, congenital malfunction, or other permanent or temporary incapacity or disability is unable, without special facilities to travel as effectively as persons who are not so affected.**

Capacity in which you know the applicant: \_\_\_\_\_

Medical diagnosis of condition causing disability (in layman's terms please): \_\_\_\_\_

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Date of onset: \_\_\_\_/\_\_\_\_/\_\_\_\_

How long have you known or worked with the applicant? \_\_\_\_\_

When did you last see the applicant? \_\_\_\_\_

Is the condition temporary? \_\_\_\_ Yes \_\_\_\_ No

Expected duration (with specific date if applicable): \_\_\_\_\_

**IF THE PERSON HAS A DISABILITY AFFECTING MOBILITY, IS THE PERSON...**

Able to walk 200 feet without assistance? \_\_\_\_ Yes \_\_\_\_ No

Able to climb three 10-inch steps without assistance? \_\_\_\_ Yes \_\_\_\_ No

If sometimes, explain: \_\_\_\_\_

Able to wait outside without support for 10 minutes? \_\_\_\_ Yes \_\_\_\_ No

If sometimes, explain: \_\_\_\_\_

Does this individual require an escort for transportation? \_\_\_\_ Yes \_\_\_\_ No

Does this person use any mobility aids? If so, what? \_\_\_\_\_

**IF THE PERSON HAS A VISUAL IMPAIRMENT...**

Visual acuity with best correction:

Right Eye \_\_\_\_\_

Left Eye \_\_\_\_\_

Both Eyes \_\_\_\_\_

Visual fields:

Right Eye \_\_\_\_\_

Left Eye \_\_\_\_\_

Both Eyes \_\_\_\_\_

**IF THE PERSON HAS A COGNITIVE DISABILITY: IS THE PERSON ABLE TO?**

Give addresses and telephone numbers upon request? \_\_\_\_ Yes \_\_\_\_ No

Recognize a destination or landmark? \_\_\_\_ Yes \_\_\_\_ No

Deal with unexpected situations or unexpected changes in routine? \_\_\_\_ Yes \_\_\_\_ No

Ask for, understand, and follow directions? \_\_\_\_ Yes \_\_\_\_ No

Safely and effectively travel through crowded and/or complex facilities? \_\_\_\_ Yes \_\_\_\_ No



Are there any other effects of the applicant's disability which the City of Madison should be aware? Please describe.

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Your name and title: \_\_\_\_\_

Office phone number: (\_\_\_\_\_) \_\_\_\_\_

The information on this application is true and correct to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_